HOME HEALTH
QUALITY REPORTING PROGRAM
PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON MARCH 5 AND 6, 2019

Current as of March 2019

Acronym List

Acronym	Definition
ALF	Assisted Living Facility
ASPEN	Automated Survey Process Environment
CASPER	Certification and Survey Provider Enhanced Reports
CEU	Continuing Education Unit)
CMS	Centers for Medicare & Medicaid Services
CoP	Condition of Participation
COTA	Certified Occupational Therapy Assistant
DC	Discharge
DRR	Drug Regimen Review
DTI	Deep Tissue Injury
EMR	Electronic Medical Record
HH	Home Health
HHA	Home Health Agency
ICD	International Statistical Classification of Diseases and Related Health Problems
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
NDNQI	National Database of Nursing Quality Indicators
OASIS	Outcome and Assessment Information Set
PAC	Post-Acute Care
PAE	Potentially Avoidable Event
PT	Physical Therapist
PTA	Physical Therapist Assistant
QAPI	Quality Assurance Performance Improvement
QRP	Quality Reporting Program
QTSO	QIES Technical Support Office
RN	Registered Nurse
ROC	Resumption of Care
SNF	Skilled Nursing Facility
SOC	Start of Care
TPN	Total Parenteral Nutrition
VBP	Value-Based Purchasing

#	Category	Item If Applicable	Question	Answer
1	Section GG		Slide 16, OASIS-D revised – I am hoping this will clarify comparing 1800s with GG items. There is much confusion that is affecting consistent data collection.	On March 6, CMS will post a factsheet called *Understanding OASIS Function M and GG Item Coding,* which will clarify that the intention is not for the codes on the GG and M items to be duplicative or always match. Each Outcome and Assessment Information Set (OASIS) item should be considered individually and coded based on guidance specific to that item. The factsheet will be posted to the Home HH QRP Training web page at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.
2	Section GG		If a patient is coming to home health from another post-acute care setting such as rehab or SNF, theoretically we should be able to ask for a copy of their OASIS note, correct?	The OASIS is specific to the Home Health care setting. Follow your agency practices for requesting discharge documentation from other care settings.
3	Section GG	GG0100C. Stairs	January 2019 Q&A guidance for GG0170N and GG0170O indicates that scooting up and down stairs or via any other safe, non-traditional manner with a portable device is captured. Does this guidance also apply to GG0100C. Stairs in the same manner?	When coding GG0100C. Prior functioning for stairs, if a patient goes up and down stairs by scooting on buttocks, code the patient's performance based on the amount of help needed to safely complete the activity.
4	Section GG	GG0110. Prior Device	Please review GG0110 again. If the patient only used a cane and no other device, we are to check walker, correct? Please clarify the rationale.	No. If a patient used a cane or a device that is not listed, check Z, None of the above.

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5	Section GG	GG0110. Prior Device	Would a lift chair be considered a mechanical lift for GG0110?	For GG0110C. Prior Device Use, a mechanical lift is defined as any device that a patient or caregiver requires for lifting or supporting the patient's bodyweight. Examples provided include a stair lift, Hoyer lift, and bathtub lift. Clinical judgment may be used to determine whether other devices, such as the electric lift chair described, meet the definition provided.
6	Section GG	GG0130. Self-Care/GG0170. Mobility	GG0130 and GG0170 instructions say "patient usual performance" and then "If activity was not attempted at SOC/ROC, code the reason." Does the clinician need to actually observe the activity, or can we question the patient about "usual performance"?	Observation is the preferred method of data collection. Additional assessment strategies include patient/caregiver report, collaboration, and assessment of similar activities.

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7	Section GG	GG0130. Self-Care/GG0170. Mobility	How specific does a nursing care plan have to be if they expect improvement and there is no therapist involved? For example, say a patient had surgery and rolling is expected to improve. Is managing pain in the care plan adequate, or do they need to be more specific regarding goals and interventions?	The intent of the function process measure is to assess patient function at SOC, ROC, and Discharge and to report a discharge goal for at least one of the activities included in the measure. Per the measure specifications, establishing a discharge goal demonstrates that a care plan addresses function. The intent of reporting a discharge goal for one or more GG Self-Care or Mobility items is to demonstrate that the agency staff assessed the patient's function and considered the impact of the anticipated or established care plan on the patient's expected discharge status in one or more functional activities. This consideration is not limited to only identifying patients or activities where functional status is expected to improve, but it also includes considering patients or activities where functional status is expected to stay the same or even decline by discharge. For each of the relevant SOC/ROC and Discharge timepoints, if the OASIS performance assessment includes a valid numeric code or an activity not attempted code (not a dash) for all 12 of the activities included in the measure and a valid numeric code or an activity not attempted code (not a dash) for the Discharge goal for at least one of the 12 activities included in the measure, then the intent of the measure has been met. For the purpose of OASIS and the function process measure, there is no expectation or requirement that the goal coded on OASIS will be specifically documented in the care plan as a goal statement or have related interventions on the plan of care. However, agencies are expected to comply with all agency policies and State and Federal regulations for care planning and documentation generally related to establishing patient goals.

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8	Section GG	GG0130. Self-Care/GG0170. Mobility	We have been told that you cannot skip the Discharge Goals because, although the patient cannot complete an activity at SOC, a goal still may be set for discharge. Is this accurate?	Even in situations where activity performance is coded with an "activity not performed" code or skipped, a discharge goal may still be reported. Use of a dash is permissible for any remaining self-care or mobility goals where a discharge goal was not established.
9	Section GG	GG0130. Self-Care/GG0170. Mobility	Please clarify what 01 for Section GG looks like. If a therapist documents in their note that someone requires supervision, I often see them selecting 06—I think that they don't think that 05 or 04 is appropriate if the "helper" is only standing there.	We interpret your question to be asking what the difference is between 06, Independent, and 04, Supervision. If a patient is able to complete an activity by him/herself with no assistance from a helper, you would code this 06. If a patient requires a helper to provide supervision, verbal cues, and/or touching/steadying or contact guard assistance as the patient completes the activity, you would code this 04.
10	Section GG	GG0130. Self-Care/GG0170. Mobility	Can you tell us whether there is a correlation between the functional M questions and the GG 0130 and 0170 questions?	Providers should not expect to see consistency between the codes of items with the same or similar names. Coding differences may be a result of what is included or excluded in the activity or what coding instructions apply to the activity. It is important to remember that each OASIS item should be considered individually and coded based on guidance specific to that item.
11	Section GG	GG0130. Self-Care/GG0170. Mobility	Which response is a better choice for the GG outcome measure, 88 or 10, in the performance or DC goals?	When coding activity not attempted codes, clinicians should use clinical judgement to determine which code is the most appropriate. Code 88 should be used when an activity was not attempted due to medical condition or safety concerns; Code 10 should be used when an activity was not attempted due to environmental limitations (e.g., lack of equipment, weather constraints). For the process measure, all the activity not attempted codes are treated the same.

#	Category	Item If Applicable	Question	Answer
12	Section GG	GG0130. Self-Care/GG0170. Mobility	If a patient scored response 3 on M1810, what response would be appropriate for GG130F, Upper body dressing: 01 or 02?	For M and GG items, do not expect to see consistency between the codes of items with the same or similar names. Coding differences may be a result of what is included or excluded in the activity or what coding instructions apply to the activity. It is important to remember that each OASIS item should be considered individually and coded based on guidance specific to that item.
13	Section GG	GG0130. Self-Care/GG0170. Mobility	Examples of non-activity codes: lives in a home and does not have 150 feet to walk, or no stairs needed/required, or usual ability does not require PT to get into care, wheelchair-bound, and does not ambulate, etc.	When completing GG0130 or GG0170, combine general observations, interviews with patient/ caregiver(s), collaboration with other agency staff, and other relevant strategies to complete any and all GG items, as needed. If the activity cannot be completed and a performance code cannot be determined based on these assessment strategies, select an appropriate activity not attempted code.
14	Section GG	GG0130. Self-Care/GG0170. Mobility	Will the training videos be posted along with the rest of the conference materials?	The decision tree document is currently available on the HH QRP Training webpage. The Section GG presentation from today's training, including live links to the video recordings, will be posted to the CMS YouTube site. We are also hoping to post standalone versions of the videos included in today's Section GG presentation along with a web-based training on Section GG shortly. As those resources are posted, we will send everyone who registered for today's HH training an email when the items are posted.
15	Section GG	GG0130. Self-Care/GG0170. Mobility	If a patient completes the activity at a level/code 6 but, for safety's sake, should be coded at a level 5, do you code 5 or 6?	Clinicians should use clinical judgement to assess the patient and determine the code for each activity based on the amount of assistance required for the patient to complete the activity. Code based on the type and amount of assistance required for a patient to complete an activity safely and as independently as possible.

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16	Section GG	GG0130. Self-Care/GG0170. Mobility	I thought the "not attempted" codes should be used rarely. If we can get the answers by asking the patient/ caregiver, is this considered a best practice?	Observation is the preferred method of data collection. Additional assessment strategies include patient/caregiver report, collaboration, and assessment of similar activities. If an activity is not completed and a performance code cannot be determined based on these assessment methods, report the appropriate activity not attempted code.
17	Section GG	GG0130. Self-Care/GG0170. Mobility	To qualify for numerator inclusion, does the goal have to be improvement or can it be sustained?	For the function process measure, it is not required that goals indicate improvement or maintenance of performance to be included in the numerator.
18	Section GG	GG0130. Self-Care/GG0170. Mobility	When you assess GG questions, are you taking safety in this assessment? I am aware that you would not attempt the activity if it's not safe, but if they do an activity and appear to need more help than they are allowing, do you score lower?	When completing assessments, clinicians should always prioritize patient's safety. If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
19	Section GG	GG0130. Self-Care/GG0170. Mobility	How should we answer discharge questions if we do a no-visit-made OASIS and the last visit made by a clinician is a PTA 6 days ago? Do you answer 09 on the GG questions or ask the patient by phone how they perform the activities?	In the case of an unplanned or unexpected discharge (an end of home care where no in-home visit can be made), the last qualified clinician who saw the patient may complete the discharge comprehensive assessment document based on information from his/her last visit. The assessing clinician may supplement the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unexpected discharge. The "last 5 days that the patient received visits" are defined as the date of the last patient visit, plus the four preceding days.

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20	Section GG	GG0130. Self-Care/GG0170. Mobility	If a patient is assessed by a nurse on day 1 and collaboration with therapy occurs on day 5 with OASIS changes, what is the day of the assessment?	When collaboration is used, other agency staff may provide information to the assessing clinician on what he/she assessed during a visit conducted during the assessment timeframe. Each person who is collaborating may provide information that was collected utilizing the existing conventions, including the "day of assessment." For example, if desired, the physical therapist (PT) who visited on Wednesday may provide information that was relevant to the PT's "day of assessment" (the 24 hours that preceded the PT's visit and the time the PT was in the home) to the registered nurse (RN) for consideration when coding the SOC/ROC assessment items.
21	Section GG	GG0130. Self-Care/GG0170. Mobility	Where is the decision tree video located?	The decision tree document is currently available on the HH QRP Training webpage. The Section GG presentation from today's training, including live links to the video recordings, will be posted to the CMS YouTube site. We are also hoping to post standalone versions of the videos included in today's Section GG presentation along with a web-based training on Section GG shortly. As those resources are posted, we will send everyone who registered for today's HH training an email when the items are posted.
22	Section GG	GG0130A. Eating	Could you code 09 for the discharge goal if rehab potential is not possible—for example, massive stroke PLOF was eating but patient will never eat by mouth again?	Yes. The code 09, not applicable, would be an appropriate goal for the scenario you described.
23	Section GG	GG0130A. Eating	Quick question – Why is "setup" still an option with regards to eating, even though eating no longer involves meal prep or serving?	Here is an example of setup when coding GG0130A, Eating: A patient requires assistance to open cartons, containers, and cutting up food from his/her family member once the food is placed in front of them.
24	Section GG	GG0130B. Oral Hygiene	GG0130B – If a patient does not have teeth or dentures, should the ability to perform other oral care be considered when responding to this item?	Oral hygiene may be applicable to an edentulous patient (a patient without teeth) and could be coded using one of the six performance codes.

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25	Section GG	GG0170. Mobility	You stated that the "not attempted? codes would be used rarely; however, some of the items are not very realistic/feasible for mobility in the home (e.g., walking 50 feet, extended wheelchair mobility, in/out of car, etc.), especially in dead of winter. Also, the burden is great for agencies (time).	Use an activity not attempted code if the activity cannot be completed and a performance code cannot be determined based on patient or caregiver report or an assessment using similar activities.
26	Section GG	GG0170. Mobility	How would you code a patient's ability to do steps if the patient needs a walker at the bottom and top but can do steps independently?	Each activity on OASIS is answered separately. Ambulation to/from the stairs is not included in the activities of GG0170M. 1 step (curb), GG0170N. 4 steps, or GG0170O. 12 steps. If the patient is able to go up and down the stairs independently with or without portable assistive devices, code 06, Independent.
27	Section GG	GG0170. Mobility	Though each GG activity stands alone, can you combine activities for assessment—for example, 50 feet with two turns and 150 feet?	The activities are coded on OASIS separately. The assessing clinician can use clinical judgement to determine how the actual patient assessment is conducted.
28	Section GG	GG0170. Mobility	If the mobility goal is set at evaluation and is not met or is exceeded at discharge, is there an option to change the OASIS goal? Does this impact our outcomes?	The function process measure reports the percent of episodes with a SOC/ROC and Discharge functional assessment and a discharge goal that addresses function. The function process measure is not impacted by whether or not the established goal is met; therefore, there is no need to modify the discharge goal after it is set at SOC/ROC.
29	Section GG	GG0170. Mobility	Does stair negotiation include bumping up/down stairs or other non-traditional methods, such as going backwards or a stair glide?	Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without portable assistive devices and/or with or without some level of assistance. This can include bumping up/down stairs. A stair glide is not a portable assistive device.

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30	Section GG	GG0130. Self-Care/GG0170. Mobility	For section GG: We have come across many scenarios where a non-activity code is utilized, especially based on patient prior level and actual "needs," but the message we are getting here is that we should limit its use? Is this correct?	Use an activity not attempted code if the activity cannot be completed and a performance code cannot be determined based on patient or caregiver report or an assessment using similar activities.
31	Section GG	GG0170C	If a patient sleeps in a recliner, how would you code the GG items, such as rolling left to right or sit to lying?	If the patient uses a recliner, sofa, or mattress on the floor as the patient's "bed" (preferred or necessary sleeping surface), assess the patient's need for assistance using that sleeping surface when determining ability in GG0170C. Lying to sitting on side of bed.
32	Section GG	GG0170D. Sit to stand	If a person had a sit to stand lift in the home, would that person be considered dependent for mobility and transfer?	Use of an assistive device, (including a sit-to-stand "stand assist") does not automatically require the reporting of a dependent code for GG0170D. If the sit to stand activity gets completed, select the performance code based on the level of assistance that is required to complete the activity. If two helpers are required to complete the sit-to-stand transfer with the stand assist lift, then code as 01, Dependent.

#	Category	Item If Applicable	Question	Answer
33	Section GG	GG0170E. Chair/bed-to-chair transfer	GG0170E scenario on slide 119 states that the nurse doesn't expect the patient's status to change, then coded the DC goal the same as SOC. Is it necessary that the care plan would have interventions related to maintaining transfer status?	The intent of the function process measure is to assess patient function at SOC, ROC, and Discharge and to report a discharge goal for at least one of the activities included in the measure. Per the measure specifications, establishing a discharge goal demonstrates that a care plan addresses function. The intent of reporting a discharge goal for one or more GG Self-Care or Mobility items is to demonstrate that the agency staff assessed the patient's function and considered the impact of the anticipated or established care plan on the patient's expected discharge status in one or more functional activities. This consideration is not limited to only identifying patients or activities where functional status is expected to improve, but it also includes considering patients or activities where functional status is expected to stay the same or even decline by discharge. For each of the relevant SOC/ROC and Discharge timepoints, if the OASIS performance assessment includes a valid numeric code or an activity not attempted code (not a dash) for all 12 of the activities included in the measure and a valid numeric code or an activity not attempted code (not a dash) for the Discharge goal for at least one of the 12 activities included in the measure, then the intent of the measure has been met. For the purpose of OASIS and the function process measure, there is no expectation or requirement that the goal coded on OASIS will be specifically documented in the care plan as a goal statement or have related interventions on the plan of care. However, agencies are expected to comply with all agency policies and State and Federal regulations for care planning and documentation generally related to establishing patient goals.

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34	Section GG	GG0170G. Car Transfer	When no car is available, if a patient can transfer on/off a chair in the home, would you code the car transfer as how much assistance the patient requires transferring on/off a chair or would you code as not attempted due to equipment?	If the car transfer activity (GG0170G) is not completed because no car is available, and the patient's status cannot be determined based on patient or caregiver report or by assessment using a similar activity, enter Code 10, Not attempted due to environmental limitations.
35	Section GG	GG0170G. Car Transfer	For the car transfer question, if there was a storm and an item was not attempted due to weather, would we code 10 (e.g., patient was discharged home from the hospital the day prior and must have gotten in and out of a vehicle), or would we ask the patient how they got in and out of the car and code based off that?	If a patient does not attempt the activity and a helper does not complete the activity, and the patient's usual status cannot be determined based on patient or caregiver report, code the reason the activity was not attempted. When using patient or caregiver report, it is expected that the patient and caregiver are reporting on the patient's status within the timeframe under consideration (e.g., reporting on the patient's ability to complete the car transfer within the past 24 hours).
36	Section GG	GG0170Q. Does patient use wheelchair and/or scooter?	If the patient only uses a wheelchair when going longer distances (usually to appointments or to pick up meds) and she wheels the chair independently once her family gets her into the chair, should GG0170Q be coded yes or no?	The intent of the wheelchair mobility item is to assess the ability of patients who are learning how to self-mobilize using a wheelchair or patients who participated in self-mobilization in a wheelchair prior to admission. If the patient is independent in propelling her wheelchair, she meets the intent of the item and a yes code would be appropriate. If the patient will not be self-mobilizing, then the correct response would be no.
37	Section GG	GG0170R. Wheel 50 feet with two turns	If there is not 50 feet of clearance in the home for wheelchair mobility but we still need to work on it, is it coded non-activity based on environmental?	In a situation where the patient's environment does not accommodate patient use of a wheelchair for 50 feet but wheelchair use for a total of 50 feet including turns is possible, a performance code may be selected based on the level of assistance needed to complete the activity. If the activity cannot be completed, select the appropriate activity not attempted code.

#	Category	Item If Applicable	Question	Answer
38	Section J: Health Conditions	M1060. Height and Weight	How do you handle weights on severely obese patients who weigh more than your facility scales read?	If a patient cannot be weighed (e.g., because of extreme pain, immobility, or risk of pathological fractures), the use of a dash (–) is appropriate. Document the rationale on the patient's medical record.
39	Section J: Health Conditions	M1060. Height and Weight	What about patients who weigh over 440 pounds?	In the unique situation that a patient's weight is greater than 440 pounds, a dash (–) should be used to enable the OASIS Assessment to be submitted.
40	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC	Why isn't a major injury caused by an external force counted in the Falls quality measure?	This quality measure is standardized across Post-Acute Care (PAC) settings and contains items that are collected uniformly in each setting's assessment instruments. The definition of a fall is standardized across the four PAC settings and specifies that falls are not a result of an overwhelming external force (e.g., a person pushes a patient).
41	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC	Can you provide an example of when a dash is a valid response regarding falls?	Clinicians are expected to review the medical record and interview the patient and caregiver to obtain the information needed for accurate coding. Use of the dash does have an impact on your reporting outcomes. A dash should only be used when no information is available.
42	Section J: Health Conditions	J1800. Any Falls Since SOC/ROC	If the dog knocked the patient over and they fractured a hip, how would this be coded?	J1800 should report any witnessed or unwitnessed fall or intercepted fall except those resulting from an overwhelming external force or those resulting from intentional therapeutic intervention intended to challenge the patient's balance for balance recovery/training.
43	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	Are there plans to address/track/trend the root cause of falls vs. injuries after falls?	No. CMS does not have plans to track/trend the root cause of falls.

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44	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	From a patient/family perspective, does CMS have any plans to align fall and injury definitions to align with NDNQI's fall and injury definitions to allow patient/caregiver education to be unified?	No.
45	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	If the measure is only when the patient had a major injury, could we simplify by having one question: "Did the patient have a fall with a major injury – yes/no"?	J1800 and J1900 items are standardized across PAC settings assessment instruments. J1800 is a gateway item for J1900. While J1900C is used to calculate the Falls with Major Injury measure, the CASPER Agency Patient-Related Characteristics (Case Mix) Report and its corresponding Tally Report provide agencies with information on their J1800 and J1900 rates that can be used to inform agency quality improvement efforts.
46	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	I find the reporting on this section odd, since the first speaker talked about meaningful measures. If a patient has a fall or intercepted fall (or a stumble) without injury, why do we want to focus so heavily on it? It seems less meaningful and overcomplicated for the clinical team to have to think about.	J1800 and J1900 items are standardized across PAC settings assessment instruments. J1800 is a gateway item for J1900. While J1900C is used to calculate the Falls with Major Injury measure, the CASPER Agency Patient-Related Characteristics (Case Mix) Report and its corresponding Tally Report provide agencies with information on their J1800 and J1900 rates that can be used to inform agency quality improvement efforts.
47	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	Is there any way to prohibit the same fall from being reported by different clinicians, causing the fall report to count it as two falls?	OASIS does not require any specific method for tracking patient falls. Use agency policies and practices.

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48	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	Great examples, but they seem to really emphasize how complex and burdensome these items are for such a simple measure. Couldn't we reduce the burden and get the information needed for the measure by a single question, "Did the patient have a fall with a Major injury?"	J1800 and J1900 items are standardized across PAC settings assessment instruments. J1800 is a gateway item for J1900. While J1900C is used to calculate the Falls with Major Injury measure, the CASPER Agency Patient-Related Characteristics (Case Mix) Report and its corresponding Tally Report provide agencies with information on their J1800 and J1900 rates that can be used to inform agency quality improvement efforts.
49	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	Code the fall no matter where it occurs, even if the fall occurred at the doctor's office?	J1800 reflects falls that occur at any time during a quality episode regardless of where the fall occurred.
50	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	What about cases of suspected domestic abuse, where the patient claims there was a fall but the bruises are inconsistent?	Information about falls can be gathered by patient or caregiver report.
51	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	Am I understanding correctly that falls are no longer a Potentially Avoidable Event (PAE)? Thank you	Application of the percent of residents experiencing one or more falls with major injury will be reported on the Outcome Report, not on the PAE Report.
52	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	It seems that only ground-level falls are being considered, please clarify.	A fall is defined as an unintentional change in position coming to rest on the ground, floor, or the next lower surface (such as a bed or chair).

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53	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	Meaningful Quality reporting is the goal, but how can CMS hold agencies accountable for data when a patient is noncompliant? For example, say the patient did not follow the recommendations given by their clinician to change home settings, and now the agency has to account for a fall. How is that meaningful for the agency?	CMS recognizes the uniqueness of the home setting, including patients' capacity to directly and independently manage their environment and healthcare needs. All of the measures adopted for the HH QRP were tested for reliability and/or validity, and CMS believes that the results of that testing support the conclusion that the measures are sufficiently reliable and valid. While we acknowledge that various patient characteristics can elevate the risk for falls, falls with major injury are considered to be "never" events, and the varying risk factors among patients does not remove the obligation of providers to minimize that risk.
54	Section J: Health Conditions	J1800. Any Fall Since SOC/ROC and J1900. Number of Falls Since SOC/ROC	You touched on documenting falls days after, but can you clarify: If we chart the fall upon the next visit, with clarification in the note that the patient was asked but clinician was not informed until days later, is that acceptable?	Follow your agency's guidelines regarding clinical documentation of falls.
55	Section J: Health Conditions	J1900. Number of Falls Since SOC/ROC	What is the difference between Scenarios 7 and 6?	Scenario 6 is considered an intercepted fall and Scenario 7 is a fall. Both are reported as falls for J1800.
56	Section J: Health Conditions	J1900. Number of Falls Since SOC/ROC	Charlotte said that the four injuries listed are not an exhaustive list and to use clinical judgement to classify falls. That is different from what is in the manual. Has this changed, or did she misspeak?	Major injury includes only bone fractures, joint dislocations, closed-head injury with altered consciousness, or subdural hematoma.
57	Section J: Health Conditions	J1900. Number of Falls Since SOC/ROC	PART 2: "…and closed head injuries with altered consciousness, or subdural hematoma) during the home health stay." If these four injury types are the definition for the quality measure, why would we categorize any other injury under J1900, Row C?	Major injury includes only bone fractures, joint dislocations, closed-head injury with altered consciousness, or subdural hematoma.

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58	Section J: Health Conditions	M1060. Height and Weight	Did you think about the cost of scales for each patient?	CMS recognizes that quality improvement efforts may require resources. While an agency may choose to purchase scales for their patients or for use by visiting staff, staff should follow agency policies and procedures, including utilizing patients' scales. If a patient cannot be weighed, a dash can be reported on M1060B. Weight.
59	Section J: Health Conditions	M1060. Height and Weight	Why were the restrictive parameters places on weight and height (e.g., for a height < 50 inches and > 80 inches, a dash is to be used, per Jan. 2019 Quarterly Q&As #2)?	The data specifications were updated to promote data collection accuracy related to the use of this item for risk adjustment. Agencies are not restricted from documenting actual height and weight in the clinical record.
60	Section J: Health Conditions	M1060. Height and Weight	Please clarify the rational for measuring the patient's height.	To calculate the Body Mass Index, which relates to the risk for pressure ulcers.
61	Section J: Health Conditions	M1060. Height and Weight	OASIS doesn't say a weight must be obtained from the agency, just within 30 days; please clarify.	Only enter a weight that has been measured by agency staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.
62	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	How should M1311 be answered at SOC/ROC if the patient refuses to have the dressing removed (e.g., the caregiver states, "I just cleaned the wound before you got here, please leave it be")?	Because the skin assessment was not conducted on the first visit, the original assessing clinician may collaborate with the second nurse (who is completing the first clinical skin assessment) regarding the presence/status of any pressure ulcers as long as the assessment is completed within 5 days of the SOC date. Providers are encouraged to complete the assessment as close to the SOC/ROC as possible.
63	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	What if the agency declines/does not perform the initial skin assessment until day 3, when the dressing can be removed?	Assuming that you are referring to a nonremovable dressing that the first nurse is visualizing, the pressure ulcer should be reported as unstageable due to a nonremovable dressing/device, as that was the status at the first skin assessment. This is true even if a second nurse observes the wound as a stageable pressure ulcer at a visit occurring within the 5-day assessment timeframe.

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64	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	At SOC there was a non-removeable dressing, and 4 days later the dressing is off. It is now seen as Stage 4; is the HHA seen as responsible for the Stage 4?	In this situation, the OASIS would be coded on the SOC as Unstageable due to non-removable dressing. In this case, once the dressing is removed and staged as a 4, the wound be considered present on admission for the discharge assessment if it is still a stage 4.
65	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	At SOC there was a non-removeable dressing, and 4 days later the dressing is off. It is now seen as Stage 4, and at discharge still has one Stage 4. How would you answer C2 at Discharge? Would it be one stage 4 present at most recent SOC/ROC?	Yes.
66	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Is a dash considered a usable response for the pressure ulcer measure in M1311? Or does a dash result in denominator exclusion?	A dash is not a usable response. A quality episode would be excluded from the denominator when a dash is the response for M1311A1, M1311B1, M1311C1, M1311D1, M1311E1, and M1311F1 at discharge.
67	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Doctors are notorious in not providing wound or ulcer classification. As an RN, can we discuss it with them and recommend a classification? And if they agree, is it acceptable that we document in the clinical record that the doctor verbally stated the classification?	A pressure ulcer/injury may be reported on OASIS based on visualization of the wound, patient assessment and interview, review of relevant related historical documentation, and clinical judgment re: etiology. Although the assessing clinician can report the observed ulcer/injury on the OASIS integumentary status items without physician confirmation, collaboration with the physician is required in order to add a diagnosis and International Statistical Classification of Diseases and Related Health Problems (ICD)-10-CM code to the OASIS diagnosis items and the patient's plan of care and to receive related orders and/or provide physician ordered care related to the pressure ulcer/injury.

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68	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Can you define and give examples of healed vs. closed?	Terminology referring to “healed” vs. “unhealed” ulcers can refer to whether the ulcer is “closed” vs. “open.” A Stage 1 pressure injury and Deep Tissue Injury (DTI), although closed (intact skin) would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a nonremovable dressing or eschar or slough, would not be considered healed. Once a Stage 3 or 4 pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed and will continue to remodel and increase in tensile strength. For the purposes of scoring the OASIS, the wound is considered healed at this point and should no longer be reported as an unhealed pressure ulcer.
69	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Clarification: If slough is present, then the stage must be 3 or 4?	A stage 2 pressure ulcer cannot have slough or eschar. If slough is present, the pressure ulcer is stage 3 or 4 or could be unstageable.
70	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	What about skin graft?	A pressure ulcer that has had a skin graft would then become a surgical wound.
71	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Is a Claggett window considered a surgical wound?	This type of procedure would not be coded at M1311.
72	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	In scenario 2, there is referral documentation indicating the presence of a stage 3. I understood you to say that you could count the stage 3 if it was documented or there was verbal hand-off, so why would you not document stage 3 as present on admission?	In Scenario 2, the known pressure ulcer /injury is covered with a non-removable dressing, so on the SOC/ROC assessment it would be coded unstageable: non-removable dressing/device. In this case, once the dressing is removed and staged as a 3, the wound would be considered present on admission for the discharge assessment if it is still a stage 3.

#	Category	Item If Applicable	Question	Answer
73	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	If agency policy allows for 5 days to finish OASIS, then wouldn't the dressing found as stage 3 in scenario 2 be considered a stage 3 pressure injury?	No, per CMS direction, the M1311 would be coded as Unstageable: non-removable dressing/devise, as you must code on what is found at the first skin assessment.
75	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Slide 14 lists GG0170C, M1028, M1060, and M1620 as "proposed risk factors." The January 2019 revised risk adjustment calculation tables don't include GG0170C, M1028, or M1060. Are these questions NOT going to be used for risk adjustment? If not, will M1028 and M1060 be removed from the OASIS?	Based on ongoing data analysis, CMS is planning on using these items to risk-adjust the quality measure of Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
76	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Would you please provide clarification on patients who have pressure ulcers with associated diabetes? Are these still pressure ulcers or are they diabetic ulcers? Nurses are having difficulty delineating between the two, especially when the wound is complex.	Pressure ulcers are defined as localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. If pressure is not the primary cause of the lesion, do not report the wound as a pressure/injury.
77	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Skin integrity in scenario 6: The patient had two stage 2 pressure ulcers on the elbow on admission but they advanced to two stage 3s, and by discharge these two stage 3 pressure ulcers has become one larger stage 3. At discharge, how many stage 3 pressure ulcers would be coded?	In this scenario, if you can longer differentiate one pressure ulcer from the other, consider it one pressure ulcer at discharge.
78	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	Although this isn't an OASIS item, please help me understand when a patient would be discharged with an unstageable wound? Would an agency be required to continue to see a patient until their wound is healed?	There could be reasons that an agency would discharge a patient from service with an unstageable wound. Examples include: discharge to hospice, discharge to another home health agency, relocation, etc.

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79	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	M1311	What if a patient allowed a partial skin assessment on Day One (e.g., didn't allow us to look at the buttocks) but then let us complete Day 4 and a pressure ulcer was found. How would this be scored? Would we be able to capture the pressure ulcer?	Because the skin assessment was not conducted on the first visit, the original assessing clinician may collaborate with the second nurse (who is completing the first clinical skin assessment) regarding the presence/status of any pressure ulcers as long as the assessment is completed within 5 days of the SOC date. Providers are encouraged to complete the assessment as close to the SOC/ROC as possible.
80	Drug Regimen Review Conducted with Follow-Up for Identified Issues		I am unable to access the med review information. Can I get a link to it please?	Training materials are available in the Downloads section of the HH QRP Training web page at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.
81	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2001: Drug Regimen Review	Does TPN need to be broken down item by item on the med list?	TPN should be considered in the Drug Regimen Review (DRR), and how it is documented within the medication profile should be based on agency policy.
82	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2001: Drug Regimen Review	Would the use of essential oils be included in the DRR, whether taken orally, diffused, or used topically?	The DRR includes all medications, prescribed and over the counter, including nutritional supplements, vitamins, and herbals administered by any route (e.g., oral, topical, sublingual, and by infusion). The DRR also includes total parenteral nutrition (TPN) and oxygen. Following these guidelines, use clinical judgment to determine whether other substances would be considered when conducting the DRR.
83	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2001: Drug Regimen Review	If our EMR's drug-to-drug review shows a potential serious interaction but the patient has been on the medications for many years without interaction, would this be considered a clinically significant issue?	A potentially clinically significant medication issue is defined as an issue that, in the care provider's clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest). The determination of whether a medication issue meets this threshold should be based on the clinician's judgment in conjunction with agency guidelines and established standards for evaluating drug reactions, side effects, interactions, etc.

#	Category	Item If Applicable	Question	Answer
84	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2001: Drug Regimen Review	If home health enters an ALF to provide services, does the clinician need to see all pill bottles if ALF manages all medications, or is an updated medication list from the facility and discussion with facility nurse sufficient (e.g., therapy only, facility has TMA administer medications)?	OASIS guidance does not specify how to compile the medication list. Follow your agency policies.
85	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2001: Drug Regimen Review	Can collaboration occur through new electronic devices such as Skype and/or Telehealth without the clinician physically present at the patient's home?	For OASIS items requiring a patient assessment, the collaborating healthcare providers (e.g., other agency clinical staff: LPN/LVN, PTA, COTA, MSW, HHA) should have had direct in-person contact with the patient or have had some other means of gathering information to contribute to the OASIS data collection (e.g., healthcare monitoring devices, video streaming, review of photograph, phone call).
86	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2001: Drug Regimen Review	How do you find your appropriate State's policy regarding what each discipline's scope of practice regarding medication? Is there a website?	OASIS does not provide guidance on State policy. Providers should refer to State resources.
87	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2001: Drug Regimen Review	If the DRR takes 4 days to complete but occurs within the SOC assessment period, would midnight of the next calendar day be when the DRR is complete? Does the full DRR have to be in one single assessment visit? We often learn more at the second visit pertaining to patient meds.	When a potential clinically significant medication is identified, the agency has until midnight of the next calendar day to notify the physician and complete any prescribed/recommended actions. The agency has up to 5 days after the SOC to complete the DRR, as part of the SOC comprehensive assessment.

#	Category	Item If Applicable	Question	Answer
88	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2003: Medication Follow-up	I do a SOC on a weekend (Saturday) and there is an interaction between medications. I called the doctor's office to make them aware, but they are closed for the weekend. What should I do, since I have until midnight of the next calendar day to notify a physician?	To report yes for M2003, the physician contact and completion of all prescribed/recommended actions must be completed by midnight of the next calendar day. This is true on weekends as well as weekdays.
89	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2003: Medication Follow-up	Has splitting M2003 into two questions ever been considered, one notifying the clinician within 24 hours and a second question for a response from the physician or designee? This could help to identify who is completing their part.	Thank you for the suggestion. CMS will take it under consideration.
90	Drug Regimen Review Conducted with Follow-Up for Identified Issues	M2005. Medication Intervention	The answer to M2001 is Yes and the answer to M2003 is No due to no response intervention by midnight of the next calendar day. There were no other medication issues during the episode. Would the answer to M2005 be No or N/A? If No, isn't that double jeopardy?	If M2003 is no, the measure is failed. In this situation, a response to M2005 does not impact the measure results.
91	General		How are we recorded if we are on the webcast?	Persons participating in the training via webcast are not recorded.
92	General		I've never used our OASIS educational coordinator. What do people typically use them for?	Each State has designated an OASIS Educational Coordinator with the responsibility to ensure that all home care providers in the State have access to training in the OASIS dataset, administration for assessing patients, and training and technical support in integrating the OASIS items into the agency's record-keeping system.

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93	General		A few years back, CMS put out OASIS training modules for providers. This was great for new employees and as a refresher for current employees. Will CMS be putting out any training modules for completion of the OASIS?	All the past trainings are posted to the CMS YouTube channel. Additionally, presentations and all the training materials used during exercises in training are posted to the HH QRP Training webpage at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html. These materials are designed as Train-the-Training materials. CMS encourages you to repurpose them with your staff. Finally, additional learning assets will soon be released. The first of these is a Section GG Web-Based Training.
94	General		How do I access the 'file folder'?	Training materials are available in the Downloads section of the HH QRP Training web page at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.
95	General		Are the rationale for the questions included in a handout?	Following the training, training materials with answers to presentations will be posted on the HH QRP Training web page at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.
96	General		Are there CEUs for this event?	No. If you are attending in person, you may be able to submit your Certificate of Completion and the agenda to your professional association. Often, professional associations will grant CEUs with this information.
97	General		Do webcast attendees get any certificate for attending?	No. Unfortunately, we cannot offer Certificates of Completion because we have no way of tracking participation.

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98	General	One Clinician Convention	The presenter emphasized the coordinated effort between the Conditions of Participation and the one clinician convention, implying that the resulting multidisciplinary approach is required. We thought the expanded collaboration was optional. Which is right?	The assessing clinician may elicit input from the patient, caregivers, and other agency staff who have had direct contact with the patient to assist in completing any or all OASIS items integrated within the comprehensive assessment document. When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources and selecting the appropriate OASIS item response(s) within the appropriate timeframe and consistent with data collection guidance. If desired, agencies may continue to limit the OASIS to only data that are directly assessed and collected by the single assessing clinician.
99	General		Why was it important to remove M2250?	OASIS item M2250 was used in the calculation on multiple process measures, which were removed from the HH Quality Initiative and HH QRP in 2017. M2250 was then removed to assist in reducing the data collection burden to agencies.
100	General		We have concerns that with the level of detail of OASIS and the requirements for understanding guidance and frequent changes in home care, we cannot focus education on staff development in evidence-based interventions to improve patient outcomes because we are so focused on OASIS assessment strategies.	CMS expects that all OASIS assessment items will be answered accurately, based upon the direction provided in the OASIS Guidance Manual.
101	General		Do OASIS Education Coordinators avail themselves for in-person learning (i.e., at the organization)?	Contact your State OASIS Education Coordinator to inquire about educational offerings.
102	General		Some of the regulations can be confusing and may be misinterpreted. Is there a specific person to contact who can clarify or simplify a regulation if we have questions?	Questions related to HH regulations and compliance may be sent to the Home Health Survey Mailbox at HHASurveyProtocols@cms.hhs.gov.

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104	General	M1021/1023. Diagnoses and Symptom Control	Will OASIS-D guidelines be updated to coincide with CoP interpretive guidance that instructs to code all active diagnoses? M1021/23 continues to state diagnoses that impact and have potential to impact.	At this time, there are no plans to update guidance for M1021/1023.
105	Reports		Is there any way that the data for reports, such as HH Compare, could be more current? For example, the last HH Compare outcomes data went through 3/31/18, 10 months past the current date. Trying to keep up with all the different dates/periods for HH Compare and VBP is challenging for QAPI efforts.	There is a data lag that occurs between the time that the OASIS assessments are completed and the time that the quality measure data are reported on HH Compare. This lag is needed to allow sufficient time for assessments and claims submission and processing, including the Review and Correct Process.
106	Reports		How many users per agency can have log ins for CASPER reports?	Generally, there is a two-person limit to access. Agencies with requests for additional staff may contact the QIES Technical Support Office (QTSO) Help Desk at Help@qtso.com with their request and rationale for the request.
107	Reports		How do we change our demographics on the reports? We bought this company 2 years ago and I already notified CMS regarding our address and ownership change, but the address stays the same.	If the information about your HHA's characteristics/administrative data (name, address, phone number, services, or type of ownership) is incorrect or has changed, you should contact your Automated Survey Process Environment (ASPEN) coordinator to make the revision. Changes to data must be updated and uploaded to the national database via ASPEN for the Compare site to be updated. When requesting updates to data, it is important to ask for updates to the data within the ASPEN system, and not just for the data on the Compare site. Please refer to: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/How-to-Update-Home-Health-Demographic-Data.html.

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108	Reports		Can we run CASPER reports quarterly, and what dates are suggested to mark?	Reports are available on demand. Most reports allow the user to specify a custom date range.
109	Reports		Will the GG quality measure be included in the HH Compare Report starting in 2020?	The GG Process Measure will be available on Review and Correct Reports on April 2019, CASPER Quality Measure Reports early 2020, and HH Compare early 2021.